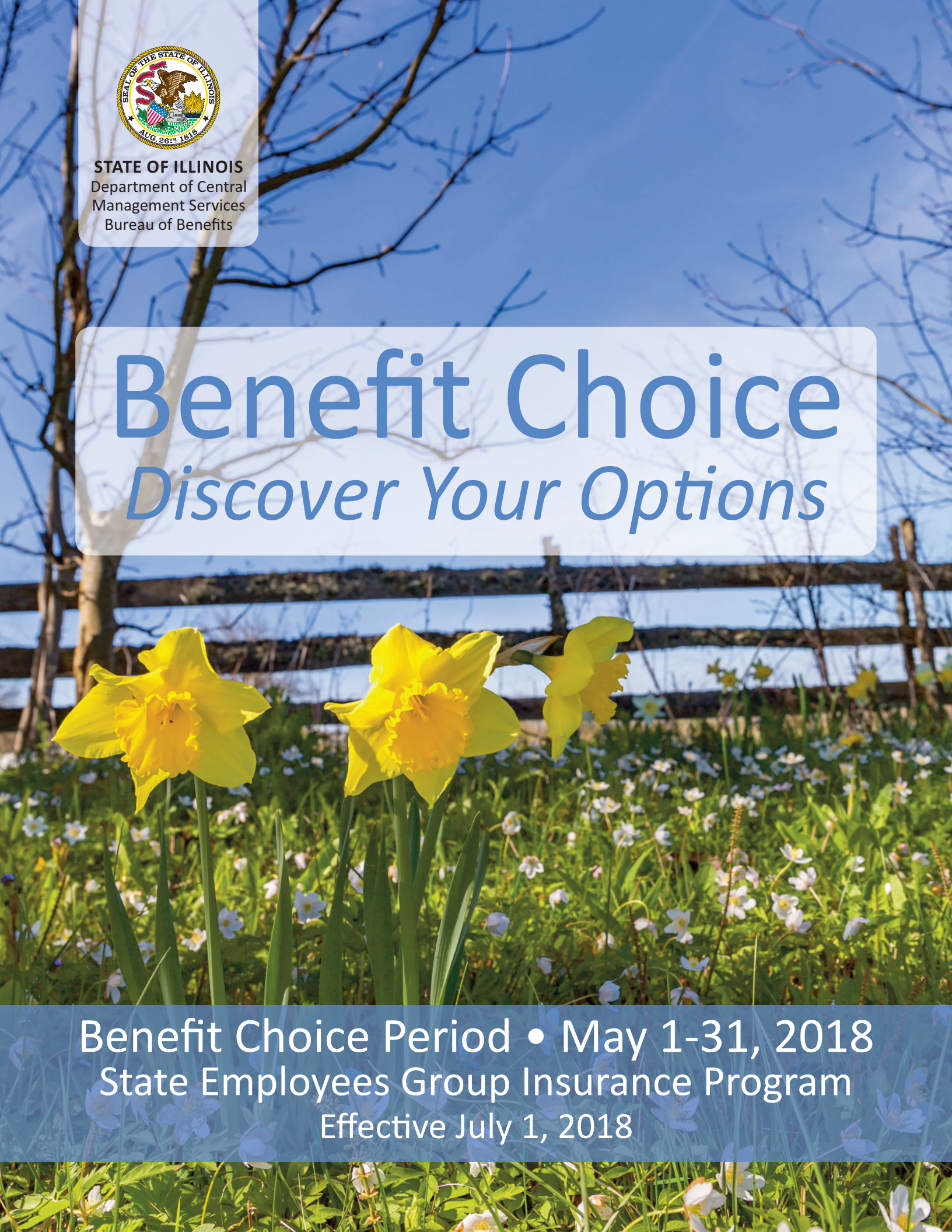


STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

Benefit Choice

Discover Your Options

Benefit Choice Period • May 1-31, 2018

State Employees Group Insurance Program

Effective July 1, 2018

Table of Contents

ONLINE ENROLLMENT PLATFORM

Making benefit elections is simple through the MyBenefits website. Follow these steps to register.

1. Log on to **MyBenefits.illinois.gov**.
2. In the top right corner of the home page, click **Login**.
3. Enter your login ID and password. If you are logging in for the first time, click Register in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice Period materials mailed to your home.
4. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles or using the decision support tool.
5. After exploring your benefit options and determining which benefits you would like to elect, follow the prompts on the welcome page.

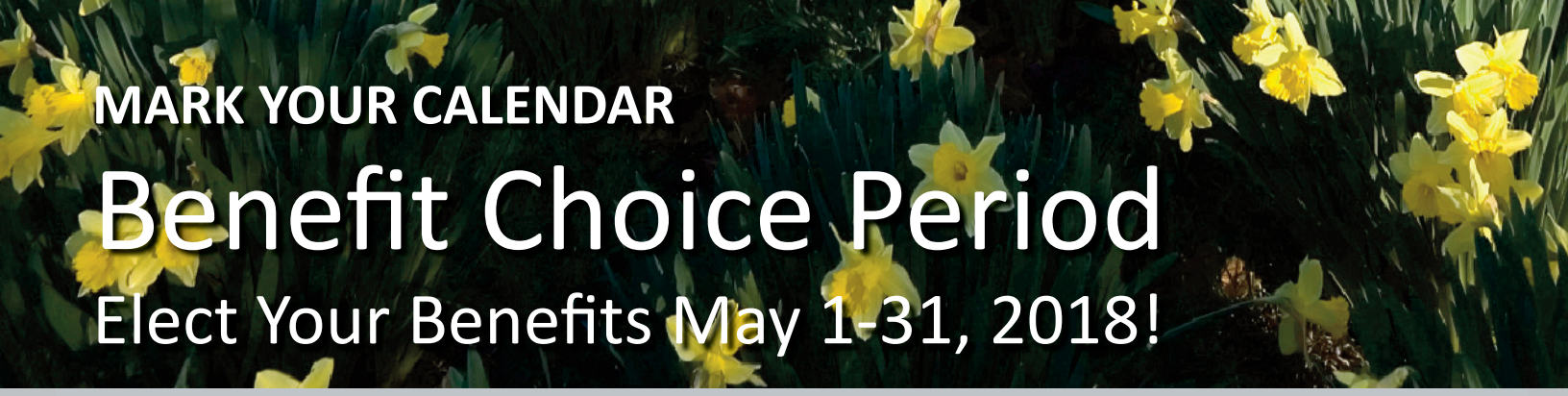
Contact MyBenefits Service Center (toll-free) 844-251-1777 or 844-251-1778 (TDD/TTY) with questions about navigating the MyBenefits website, or how to elect benefits. Representatives are available Monday – Friday, 8:00 AM – 6:00 PM CT.

WHAT YOU NEED TO DO

1. Go to MyBenefits.illinois.gov to review your benefit options.
2. Choose the benefits you'd like to elect on the MyBenefits website May 1-31, 2018.
3. Consider going paperless. Provide your email address on the MyBenefits website to receive quick responses and notifications through electronic communications.
4. Take advantage of your new benefits which will become effective July 1, 2018.

DISCLAIMER

The health plan options outlined in this Benefit Choice book are subject to change pending final resolution of the collective bargaining process and litigation arising from that process. If that process results in significant changes in plan designs, benefit levels, or premiums, a second Benefit Choice Period may be held for any members impacted by such changes. If a second Benefit Choice Period is held, members will have the opportunity to change plans at that time with updated information. For the latest information, please continue to visit MyBenefits.illinois.gov and Benefitschoice.il.gov.



MARK YOUR CALENDAR

Benefit Choice Period

Elect Your Benefits May 1-31, 2018!

TAKE ACTION! Read about your benefits here, and choose your coverage for the coming year.

What is Changing

Medical Care Assistance Plan (MCAP)

The MCAP maximum contribution amount will be $2,650 for the FY19 plan year with a $500 maximum rollover. Employees must re-enroll in MCAP for the new plan year in order to qualify for the rollover.

Life Insurance

Basic life insurance continues to be provided at no cost to all active members and annuitants. However, Member Optional Life insurance rates will be decreasing. Now is the the time to reevaluate your life insurance coverage. See page 14 for additional details.

What is Not Changing

The MyBenefits online enrollment platform, launched last year, will continue to be of service to all of our members. A simplified plan comparison and election process is provided through online enrollment at MyBenefits.illinois.gov or by calling the MyBenefits Service Center (toll-free) 844-251-1777.

Premiums

Employee and dependent premiums will remain the same for this Benefit Choice Period.

Plan Administrators

Plan administrators will remain the same for all plans including health, dental, vision, behavioral health, prescription drugs, Flexible Spending Accounts, and life insurance.

Health Plan Options

There will be no changes to your health plan options this Benefit Choice Period. **If you wish to keep your coverage, no action is needed unless you intend to enroll or re-enroll in a Flexible Spending Account.** If you wish to change your plan, carrier, or re-enroll in a Flexible Spending Account, go online at MyBenefits.illinois.gov.

Health

The State of Illinois offers comprehensive health plan options, all of which include prescription drug, behavioral health, and vision coverage.

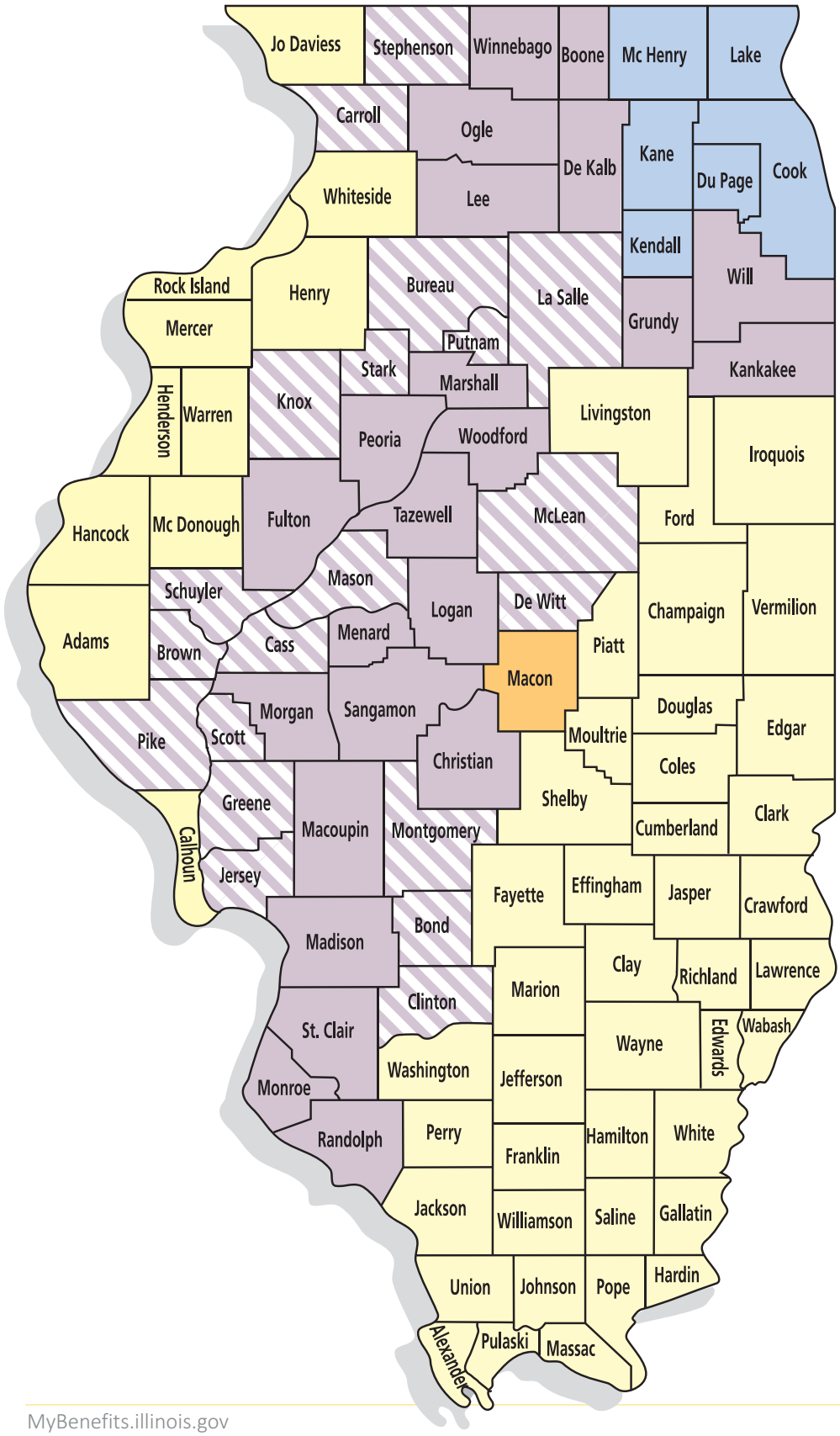
Consider your health needs as you select between QCHP, HMO, and OAP plans.

- Quality Care Health Plan (QCHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a QCHP in-network provider. QCHP has a nationwide network of providers through Aetna for medical services, CVS/caremark for prescription drug benefits, and Magellan Health Services for behavioral health services.
- Health Maintenance Organizations (HMO) members are required to stay within the health plan provider network. No out-of-network services are available. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization.
- Open Access Plans (OAP) members will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted.
  - Tier I offers a managed care network which provides enhanced benefits and operates similar to an HMO.
  - Tier II offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
  - Tier III covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involves higher out-of-pocket costs. Furthermore, members who use out-of-network providers will be responsible for any amount that is more than the charges allowed by the plan for services (allowable charges), which could result in substantial out-of-pocket costs.

Members enrolled in an OAP can mix and match providers and tiers.

What is Available in Your Area in FY19

Review the following map and charts to compare plans. Then, review your monthly contribution and out-of-pocket maximums to determine which plan is best for you.



Aetna HMO
BlueAdvantage HMO
Health Alliance HMO
HMO Illinois
Aetna OAP
HealthLink OAP
Quality Care Health Plan (QCHP)

BlueAdvantage HMO
HMO Illinois
Aetna OAP
HealthLink OAP
Quality Care Health Plan (QCHP)

Aetna HMO
Health Alliance HMO
Aetna OAP
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Aetna HMO
BlueAdvantage HMO
Health Alliance HMO
HMO Illinois
Aetna OAP
HealthLink OAP
Quality Care Health Plan (QCHP)

Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.

YOUR PLAN OPTIONS: A HIGH LEVEL COMPARISON

See page 8 for monthly contributions.

Additional health plan or prescription drug information can be viewed and compared online through the MyBenefits website at MyBenefits.illinois.gov. Click the Health Plan tile on the home page.

HMO Administrators

- Aetna HMO
- BlueAdvantage HMO
- Health Alliance HMO
- HMO Illinois

OAP Administrators

- Aetna OAP
- HealthLink OAP
- *Prescription Drug Coverage through CVS/caremark*

QCHP Administrators

- Quality Care Health Plan (Aetna)
- *Prescription Drug Coverage through CVS/caremark*
- *Behavioral Health Services through Magellan Health Services*

Benefits are outlined in the plan's Summary Plan Document (SPD) located on the providers' websites. It is the member's responsibility to know and follow the specific requirements of the plan. Contact the plan administrator for a copy of the SPD.

HMO Benefits

Members must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the member pays only a copayment. No annual plan deductibles apply. However, there is an annual $100 prescription deductible per enrollee. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan administrator for a copy of the SPD.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $350 copayment per admission
Alcohol and substance abuse	100% after $350 copayment per admission
Psychiatric admission	100% after $350 copayment per admission
Outpatient surgery	100% after $250 copayment per visit
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $250 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after $20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment per visit
Prescription drugs (30-day supply) ($100 deductible applies; formulary is subject to change during plan year)	$8 copayment for generic $26 copayment for preferred brand $50 copayment for nonpreferred brand
Durable Medical Equipment	80%
Home Health Care	$30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan administrator for a copy of the SPD. A $100 prescription drug deductible applies to each enrollee.

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network)** 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum Per Individual Enrollee Per Family	$6,600 (includes eligible charges from Tier I and Tier II combined) $13,200 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Annual Plan Deductible (must be satisfied for all services)	$0	$250 per enrollee*	$350 per enrollee*
Hospital Services			
Inpatient	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Psychiatric	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $350 copayment per admission	90% of network charges after $400 copayment per admission	60% of allowable charges after $500 copayment per admission
Emergency Room	100% after $250 copayment per visit	100% after $250 copayment per visit	100% after $250 copayment per visit
Outpatient Surgery	100% after $250 copayment per visit	90% of network charges after $250 copayment	60% of allowable charges after $250 copayment
Diagnostic Lab and X-ray	100%	90% of network charges	60% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $20 copayment	90% of network charges	60% of allowable charges
Specialist Office Visits	100% after $30 copayment	90% of network charges	60% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $20 or $30 copayment	90% of network charges	60% of allowable charges
Other Services			
Prescription Drugs – $100 deductible applies Copayments (30-day supply) | Generic $8 | Preferred Brand $26 | Nonpreferred Brand $50			
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
Skilled Nursing Facility	100%	90% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	90% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	90% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

Quality Care Health Plan (QCHP) Benefits - Aetna

Plan Year Maximums and Deductibles		
Plan Year and Lifetime Maximum	Unlimited	
Employee's Annual Salary (based on each employee's annual salary as of April 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
$60,700 or less	$375	$937
$60,701 - $75,900	$475	$1,187
$75,901 and above	$525	$1,312
Retiree/Annuitant/Survivor	$375	$937
Dependents	$375	N/A
Additional Deductibles*	Each emergency room visit $450 QCHP hospital admission $100 Non-QCHP hospital admission $500	

Out-of-Pocket Maximum Limits			
In-Network Individual $1,500	In-Network Family $3,750	Out-of-Network Individual $6,000	Out-of-Network Family $12,000

Hospital Services	
QCHP Hospital Network	$100 deductible per hospital admission. 85% after the annual plan deductible.
Non-QCHP Hospitals	$500 deductible per hospital admission. 60% of allowable charges after the annual plan deductible.

Outpatient Services	
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.
Diagnostic Lab/X-ray	85% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the QCHP Network	85% after the annual plan deductible.
Services not included in the QCHP Network	60% of allowable charges after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	85% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.

Transplant Services	
Organ and Tissue Transplants	85% after $100 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Aetna. To assure coverage, the transplant candidate must contact Aetna prior to beginning evaluation services.

Prescription Drugs		
Plan Year Pharmacy Deductible		$125
Copayments (30-day supply)	Generic	$10
	Preferred Brand	$30
	Nonpreferred Brand	$60

* These are in addition to the plan year deductible.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

Monthly Contributions

The State shares the cost of health coverage with you. While the State covers the majority of the cost, you must make monthly contributions determined by your annual salary. The following chart outlines monthly contribution rates for full-time members. Note that part-time members are required to pay a percentage of the State's portion of the monthly contribution in addition to their own.

Employee Annual Salary	Employee Monthly Health Plan Contribution Amounts	
	Managed Care	**Quality Care**
$30,200 & below	$68	$93
$30,201 - $45,600	$86	$111
$45,601 - $60,700	$103	$127
$60,701 - $75,900	$119	$144
$75,901 - $100,000	$137	$162
$100,001 & above	$186	$211

Members who retire, accept a salary reduction, or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary. This applies to members who return to work after having a 10-day or greater break in State service after terminating employment. This does not apply to members who have a break in coverage due to a leave of absence.

Retiree, Annuitant and Survivor Monthly Health Plan Contributions	
20 years or more of creditable service	$0
Less than 20 years of credible service and SERS/ SURS annuitant/survivor on or after 1/1/98 or TRS annuitant/survivor on or after 7/1/99.	Five percent (5%) of the costs of the basic program of group health benefits for each year of service less than 20 years.

DISCLAIMER

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY19. For future years, the State reserves the right to designate the plan options which constitute the basic program of health benefits and to require additional contributions in accordance with the law for any optional coverage elected by an annuitant, retiree, or survivor.

Dependent Monthly Health Plan Contributions

In addition to monthly contributions for their own health coverage, members must make additional monthly contributions for dependents they cover. Dependents must be enrolled in the same plan as the member. The Medicare dependent monthly contribution applies only if Medicare is primary for both Parts A and B.

Health Plan Name and Code	1 Dependent	2+ Dependents	1 Medicare A and B Primary Dependent	2+ Medicare A and B Primary Dependents
Aetna HMO	$111	$156	$ 88	$130
Aetna OAP	$111	$156	$ 88	$130
BlueAdvantage HMO	$ 96	$132	$ 75	$110
Health Alliance HMO	$113	$159	$ 89	$133
HealthLink OAP	$126	$179	$102	$149
HMO Illinois	$100	$139	$ 79	$116
Quality Care Health Plan (Aetna)	$249	$287	$142	$203

Adding a Dependent

If you add a dependent for the first time this year, you must provide the required documentation to complete enrollment, no later than June 11, 2018. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan. Note: Any documentation received after May 31, 2018, may result in a delay of ID cards.

Transition of Care after Health Plan Change

Members and their dependents who elect to change health plans and are then hospitalized prior to July 1 and discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services. Members or dependents who are involved in an ongoing course of treatment or have entered the third trimester of pregnancy should contact their new plan administrator before July 1 to coordinate the transition of services for treatment.

OPT OUT

Full-time employees, retirees, annuitants, and survivors have the option to opt out of health coverage if they have other comprehensive coverage provided by an entity other than the Department of Central Management Services. Proof of other coverage and appropriate documentation must be submitted. Be advised that if you have previously opted out of benefits, you can re-enroll only during the Benefit Choice Period.

Note: If you are not currently enrolled in benefits due to previous nonpayment of premiums, contact the Premium Collection Unit to discuss your Benefit Choice Options 217-558-4783.

Qualifying Changes in Status

After the Benefit Choice Period ends, you will only be able to change your benefits if you have a qualifying change in status.

You must report a qualifying change in status on the MyBenefits website within 60 days of the event to be eligible to make benefit changes. Also note that it is required to report important events to the MyBenefits Service Center, including a change in Medicare status. To report a leave of absence, unpaid time away from work, or to report a financial power of attorney, please contact your Group Insurance Representative (GIR).

State Employees Group Insurance Program

Medicare Requirements

Each member and dependent must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that the member and/or dependent is eligible for Medicare Part A at a premium-free rate, the member and/or dependent is required by the State to enroll in Medicare Part A. Retirees and survivors, as well as employees without current employment status (on a disability leave of absence), must also enroll in Medicare Part B, if eligible. Once enrolled in Medicare, the member and/or dependent is required to send a front side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a member is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the member must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty.

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

Total Retiree Advantage Illinois
Your Trail to Better Health

The State of Illinois offers retirees, annuitants and survivors a healthcare program referred to as the TRAIL. This program provides eligible members and their covered dependents comprehensive medical and prescription drug coverage through State-sponsored Medicare Advantage Prescription Drug Plans. In order to be eligible for the TRAIL MAPD program, a member (and all covered dependents) must be enrolled in Medicare Parts A and B and be a resident of the United States (or a US territory). The Department of Central Management Services (CMS) will notify all eligible members by mail prior to the start of the TRAIL Open Enrollment Period this fall. The TRAIL Open Enrollment Period runs from the middle of October through the middle of November each year. All elections made during the TRAIL Open Enrollment Period will be effective January 1st. **All newly eligible members must enroll** into a State-sponsored TRAIL plan or opt out of State insurance coverage during the fall open enrollment period. Members already enrolled in a TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes.

For more information regarding the Medicare Advantage 'TRAIL' Program, go to MyBenefits.illinois.gov or contact the State of Illinois Medicare COB Unit, PO Box 19208, Springfield, Illinois 62794-9208, Fax: 217-557-3973.

Dental

The State's Quality Care Dental Plan (QCDP) offers a comprehensive range of benefits and is available to all members. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits on the MyBenefits website.

The dental plan has an annual plan deductible. Once the deductible has been met, each member is subject to a maximum dental benefit, including orthodontia, for both in-network and out-of-network providers.

Deductible and Plan Year Maximum	
Annual deductible for preventive services	N/A
Annual deductible for all other covered services	$175
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
In-network plan year maximum benefit	$2,500
Out-of-network plan year maximum benefit	$2,000

It is strongly recommended that plan members obtain a pretreatment estimate through Delta Dental for any service over $200. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.

Child Orthodontia Benefit

Length of Orthodontia Treatment	Maximum Benefit	
	In-Network	**Out-of-Network**
0 - 36 Months	$2,000	$1,500
0 - 18 Months	$1,820	$1,364
0 - 12 Months	$1,040	$780

Member Monthly Quality Care Dental Plan (QCDP) Contributions*		
Member Only	**Member + 1 Dependent**	**Member + 2 or More Dependents**
$11	$17	$19.50

* Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see MyBenefits.illinois.gov for more information).

Vision

Vision coverage is provided at no cost to all members enrolled in a State health plan. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected.

Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	$25 copayment	$30 allowance	Once every 12 months
Spectacle Lenses* (single, bifocal and trifocal)	$25 copayment	$50 allowance for single vision lenses $80 allowance for bifocal and trifocal lenses	Once every 12 months
Standard Frames	$25 copayment (up to $175 retail frame cost; member responsible for balance over $175)	$70 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	$120 allowance	$120 allowance	Once every 12 months

* Spectacle Lenses: Member pays any and all optional lens enhancement charges. In-network providers may offer additional discounts on lens enhancements and multiple pair purchase.

** Out-of-network claims must be filed within one year from the date of service.

Flexible Spending Accounts

Save on eligible health and dependent care expenses through a tax-advantaged Flexible Spending Account (FSA). All active employees are eligible to enroll in an FSA during the Benefit Choice Period. This benefit is not available to retirees and annuitants.

The State offers two types of FSAs – the Medical Care Assistance Plan (MCAP) and Dependent Care Assistance Plan (DCAP) – both of which are funded through pre-tax payroll contributions.

MCAP

MCAP is an account that allows you to set aside pre-tax, per paycheck contributions for you and your eligible dependents, to pay for health-related expenses not covered by insurance, including doctor, dentist, or prescription drug copays, coinsurance, or other eligible out-of-pocket expenses. To make paying those expenses easier, participants will be provided a debit card at no cost. Documentation may be required to substantiate certain expenses paid with the debit card.

The MCAP maximum contribution limit is $2,650 for the FY19 plan year with a $500 maximum rollover. Note that participants who do not re-enroll for the new plan year will forfeit any amount eligible for rollover.

DCAP

DCAP is an account that allows you to set aside pre-tax, per paycheck contributions to pay for dependent care expenses, such as child care for children under age 13 or care for a physically or mentally disabled dependent. DCAP cannot be used for dependent medical expenses or for children for which you are not considered the primary or custodial parent.

You must re-enroll every year to continue participating. Remember that your FSA elections do not carry over from year-to-year. Re-enroll by logging on to MyBenefits.illinois.gov and completing the enrollment process by May 31, 2018.

You have until September 30, 2019, to submit claims for services incurred from July 1, 2018 through June 30, 2019; otherwise, any money left in your account will be forfeited, with the exception of the $500 MCAP maximum rollover. Likewise, those enrolled in FSAs this current plan year have until September 30, 2018, to submit claims for services incurred from July 1, 2017 through June 30, 2018.

Life

Basic Life Insurance is provided at no cost to all active members, retirees and annuitants. Active employees receive an amount equal to their annual salary. Retirees and annuitants under age 60 receive an amount equal to their annual salary on their last day of active employment. Retirees and annuitants age 60 or older receive a $5,000 benefit.

BENEFICIARY ELECTIONS

Don't forget to elect your beneficiaries and make the appropriate updates when necessary to ensure that your Life Insurance benefit is paid out according to your wishes. Remember, you may also have death benefits through various state-sponsored programs, each having a separate beneficiary form, including Life Insurance, retirement benefits, and the Deferred Compensation Program.

Member Optional Life coverage is available to active members, retirees and annuitants under age 60 at 1-8 times their Basic Life amount and to retirees and annuitants age 60 or older at 1-4 times their Basic Life amount. The maximum benefit allowed for Member Optional Life plus Basic Life is $3,000,000. Rate changes due to age go into effect the first pay period following the member's birthday.

Optional Term Life Rate	
Member Age	**Monthly Rate Per $1,000**
Under 30	$0.02
30 – 39	$0.06
40 – 49	$0.08
50 – 54	$0.16
55 – 59	$0.36
60 – 64	$0.62
65 – 69	$1.22
70 and above	$2.02

Accidental Death & Dismemberment (AD&D) is available to eligible members in an amount equal to either their Basic Life amount or the combined amount of their Basic and Member Optional Life, subject to a total maximum of 5 times their Basic Life amount or $3,000,000, whichever is less.

AD&D Monthly Rate Per $1,000
$0.02

Spouse Life coverage is available in a lump-sum amount of $10,000 for the spouse of active members, retirees and annuitants under age 60 or $5,000 for the spouse of retirees or annuitants age 60 and older.

Spouse Life Monthly Rates	
Spouse Life $10,000 Coverage (Members, retirees and annuitants under age 60)	$6.00
Spouse Life $5,000 Coverage (Retirees and annuitants age 60 and older)	$3.00

Child Life coverage is available in a lump-sum amount of $10,000 per child. The monthly contribution applies to all dependent children regardless of the number of children enrolled. Eligible children include children age 25 and under or children in the disabled category.

Child Life Monthly Rate	
Child Life $10,000 Coverage	$0.70

An EOI (Evidence of Insurability) is required for members to add/increase optional life or to add Spouse Life. EOI is not needed to add Child Life coverage.

Wellness

The State offers wellness programs to help members lead better, healthier, and more satisfying lives. The following programs focus on improving lifestyle choices, including eating healthier, being more physically active, ending tobacco use, managing stress, and avoiding, stabilizing, or improving chronic health problems. Check out the following programs and consider which may be right for you.

Disease Management

Disease Management Programs target and assist those identified as having certain risk factors for chronic conditions, like diabetes and cardiac health. If you have been identified as having risk factors and meet the appropriate medical criteria, you may be contacted by your health plan administrator to participate in one of these highly confidential programs.

Behavioral Health Services

The State recognizes that the holistic health of their members encompasses more than physical health, and offers behavioral health services automatically to those enrolled in a State health plan.

If you are enrolled in a QCHP health plan, contact Magellan Health Services (see page 17). If you are enrolled in an HMO or OAP health plan, contact your plan administrator.

Employee Assistance Program (EAP) & Personal Support Program (PSP)

The Employee Assistance Program (EAP) is a free, voluntary, and confidential service for all active State members and their dependents experiencing hardship in managing relationships, finances, work, education, or other life issues. Counselors are available to provide problem identification, counseling, and referral services, regardless of the medical plan chosen. For EAP services, contact Magellan Health Services (see page 17).

Note that the EAP is for active members not represented by the collective bargaining agreement between the State and AFSCME Council 31.

The Personal Support Program (PSP) is similar and parallel to the EAP program, however, PSP is for members within the bargaining unit. The Personal Support Program (PSP) is administered by AFSCME (see page 17 for contact information).

Smoking Cessation

Quit smoking with the help of the State's Smoking Cessation Program. Eligible members are entitled to receive up to a $200 rebate every year, upon the completion of the program. Visit MyBenefits.illinois.gov for additional information.

Weight-Loss

Members who utilize weight-loss programs may be eligible for up to a $200 rebate, once every three plan years. Visit MyBenefits.illinois.gov for additional information.

WHAT YOU CAN DO

1. **Get annual preventive checkups and health screenings.** Your health plan covers many preventive services at no cost to you.
2. **Know your numbers.** Get biometric screenings from your doctor during your annual physical – quick and easy tests that measure your blood pressure, pulse rate, blood glucose, total cholesterol, and body mass index.
3. **Take a Health Risk Assessment (HRA)** through your health plan administrator's website – a confidential assessment with health-related questions that, once completed, suggests a personal action plan to improve your health. Results are most accurate when combined with a biometric screening.

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits – Morneau Shepell 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	MyBenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285654) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	Aetna OAP (Group Number 285650) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	Quality Care Health Plan (QCHP) - Aetna PPO (Group Number 285658) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06800) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
	Health Alliance Medical Plans (Group Number 000010) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/stateofillinois
	HealthLink OAP (Group Number 160000) PO Box 411580, St. Louis, MO 63134	800-624-2356 800-624-2356 ext. 6280 (TDD/TTY)	healthlink.com/illinois_index.asp
	HMO Illinois (Group Number H06800) PO Box 981106, El Paso, TX 79998-1106	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
Prescription Drug Plan	CVS/caremark (for QCHP or OAP Plans) Group Numbers: (QCHP 1400SD3) (Aetna OAP 1400SCH) (HealthLink OAP 1400SCF) **Paper Claims:** CVS/caremark PO Box 52136, Phoenix, AZ 85072-2136 **Mail Order Rx:** CVS/caremark PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 800-526-0844 (TDD/TTY)	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20240) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Life Insurance	Securian/Minnesota Life Insurance Company 536 Bruns Lane, Unit 3, Springfield, IL 62702	888-202-5525 800-526-0844 (TDD/TTY)	lifebenefits.com/Illinois
Flexible Spending Accounts (FSA)	ConnectYourCare PO Box 622317, Orlando, FL 32862-2317	888-469-3363 800-526-0844 (TDD/TTY) 443-681-4602 (fax)	connectyourcare.com
Commuter Savings Program (CSP)	Commuter Check Direct Claims Administrator 320 Nevada Street, Newton, MA 02460	888-235-9223 844-878-0594 (TDD/TTY)	commutercheckdirect.com
Behavioral Health	Magellan Health Services (QCHP Group Number 3181456) PO Box 2216, Maryland Heights, MO 63043	800-513-2611 (nationwide) 800-526-0844 (TDD/TTY)	magellanassist.com
Employee Assistance Program (EAP)	Magellan Health Services	866-659-3848 (nationwide) 800-456-4006 (TDD/TTY)	magellanassist.com
Personal Support Program (PSP – AFSCME EAP)	AFSCME Council 31	800-647-8776 (statewide) 800-526-0844 (TDD/TTY)	afscme31.org
State Employees' Retirement System	2101 South Veterans Parkway PO Box 19255, Springfield, IL 62794-9255	217-785-7444 217-785-7218 (TDD/TTY)	state.il.us/srs
State Universities Retirement System	1901 Fox Drive PO Box 2710, Champaign, IL 61825-2710	800-275-7877 800-526-0844 (TDD/TTY)	surs.org
Teachers' Retirement System	2815 West Washington PO Box 19253, Springfield, IL 62794-9253	877-927-5877 (877-9-ASK-TRS) 866-326-0087 (TDD/TTY)	trsil.org

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for State of Illinois Medicare-eligible Plan Participants

This Notice confirms that the State Employees Group Insurance Program (SEGIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through SEGIP is, on average, as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan.

Because your existing coverage is Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your coverage through SEGIP and experience a continuous period of 63 days or longer without Creditable Coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your SEGIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your SEGIP coverage ends.

If you keep your existing group coverage through SEGIP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a Benefits Confirmation Statement as a Notice of Creditable Coverage by contacting the MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY).

Summary of Benefits and Coverage (SBC) and Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The summary is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in coverage, or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All State health plan SBCs, along with the glossary, are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated on the MyBenefits website, effective July 1, 2018. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at MyBenefits.illinois.gov.

Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208

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